Intimacy in clinical practice: discovery or care?

Intimacy is not a word often associated with clinical practice, except in the context of 'intimate clinical examination'. Nonetheless, it is a concept that may bear some examination. Clinicians shy away from the term because it suggests the kind of relationship with a patient that transgresses professional boundaries, yet at the same time they need to deal with the paradox that the doctor-patient relationship requires intimacy of both a physical and psychological nature. Physical examination necessitates touch, and psychiatric examination involves probing into thoughts and feelings usually left unexposed. The intimacy of modern clinical practice is an intimacy of discovery: clinicians use touch and questioning to elicit information that will lead to diagnosis. It is a lop-sided kind of intimacy: there is no reciprocation of the discovery; no reciprocity of touch or understanding. The doctor uncovers, discovers and diagnoses, and the patient is subject to treatment.

The words that spring easily to the pen when thinking about intimacy in a professional context imply unwanted intrusion: words such as 'probing',' insertion' and 'exposure'. 'Intimacy' itself is a dirty word, applicable to sexual relations rather than clinical contact. Professional health care in the twenty-first century would rather keep intimacy at arm's length; pretend it is not happening so that no-one is embarrassed. Our modern sensibility, as the sociologist Julia Twigg observes, emphasises the '"purified" body, contained, individual and clearly bounded'. This was not always the case. Our bodies have not always been so hidden; non-sexual touching has not always been anathema. This discussion reflects on the nature of physical intimacy – especially touch – within a health care context, what characterises it now and how insights from the past may help us to understand its potential power not for intrusion and abuse but for healing.

Before medical advances made it possible to do as much for sick people as we now can, considerably greater value was placed on intimate physical care of the body. Intimacy was not just a matter of finding out but of *doing* or *healing*. Intimacy held special power in the medieval period, when medicine was limited almost exclusively to palliative care. In this world, cures were rare and illness mysterious, often attributed to supernatural causes. Medieval writing reflects the hope for divine intervention or medical marvel in its repeated images of healers possessed of holy or magical powers. Touch is the instrument of both, reflecting both its importance in palliative care, and its prominent role in the healing miracles effected by Christ and the prophets. The connection between touch and feeling is repeatedly emphasised in medieval romance, where women tend and heal the wounds of their beloved knights. Thus Malory in his *Morte Darthur* emphasises the conjunction of medical knowledge and love in describing how Tristan's wounds are healed by his lady, La Beale Isode, who is 'a noble surgeon': 'whan she had serched hym she founde in the bottom of his wounde that therein was poyson, and so she healed hym in a whyle' (VIII, 9, p. 238). Love guides the intimate process of care. Most striking is Malory's depiction of the healing of Sir Urry, whose poisoned wounds, effected by a sorceress, will never be whole until they are searched by 'the beste knyght of the worlde' (XIX, 10). Of all King Arthur's hundred and ten knights, only Sir Launcelot succeeds, and the scene demonstrates his virtue and humility: he weeps 'as he had bene a chylde that had bene beatyn!' (XIX, 12, p. 668). Here, the power of intimacy is divinely sent, the miracle of healing reflecting Launcelot's spiritual perfection But in all these cases, there is a profound correspondence between the healing power of touch and feeling - whether this is spiritual, romantic or simply human

Intimacy, especially in relation to touch, is essential to the way in which healing is effected in early imaginative writing. But crucial also is the empathetic nature of care: the carer and cared-for are connected by bonds of family or affection or Christian love. Later literature repeatedly depicts

family members attending the bedsides of sick relatives, watching over their bodies, mopping their fevered brows, waiting for the crisis of an illness to claim them or to break. Elinor Dashwood watches over her sister Marianne throughout the night, 'carefully administering the cordials prescribed' until she sleeps. *Bleak House* takes such devotion beyond the immediate family, famously depicting Esther Summerson's selfless care of the homeless street-sweeper Jo (and later of her maid Charley), and her consequent contraction of smallpox. Florence Nightingale emphasises the universal importance of ministering to the body in her *Notes on Nursing*: The nurse takes on the intimate, familial role of care:

> The amount of relief and comfort experienced by the sick after the skin has been carefully washed and dried, is one of the commonest observations made at a sick bed. But it must not be forgotten that the comfort and relief so obtained are not all. They are, in fact, nothing more than a sign that the vital powers have been relieved by removing something that was oppressing them. The nurse, therefore, must never put off attending to the personal cleanliness of her patient under the plea that all that is to be gained is a little relief, which can be quite as well given later.

There are striking echoes here of medieval depictions of the relief of pain and illness through the power of intimate care.

Presence, watching and touch characterise these accounts and are seen as essential to the physical care and healing of the body. Such ministering to the sick, once most likely to be the task of family members, has now become the preserve of professional carers, and intimacy has become rarer. Julia Twigg, writing on bathing and care in the community, comments on this cultural change:

> ...modern western society is less tactile compared with non-western societies and the historical past ... touch in modern life has become increasingly confined to erotic relations, so that adults, particularly men, live in a world that is largely atactile except for sex.

The only other context in western society where individuals regularly enjoy intimate touch is in their relations with babies and children. However, a barrier tends to descend once children reach adolescence and this trend has been aggravated by the apparent pervasiveness of child sexual abuse. That this loss of intimacy matters is suggested by the experience of one elderly woman interviewed by Twigg, who described being bathed as 'lovely, like being a baby again'.

It seems, then, that in western society adult experience of physical intimacy is either with sexual partners or occurs in the context of professional care at the end of life or in illness. We have lost the habit of intimate care-giving within the home, yet nonetheless our bodies still crave this closeness and need its healing power. Why is this important for clinical medicine? In modern clinical medicine, the interpersonal and relational have been replaced by the technical. Doctors examine through instruments and now rely much more on imaging rather than examining to understand what is happening beneath the skin. This is the intimacy of discovery rather than of interpersonal care.

The implication of this for medicine is that the intimacy of discovery places the focus on doctors and their needs, rather than attending to the experience of the patient. Drew Leder and Mitchell Krucuff identity two kinds of touch prevalent in modern medical practice: 'objectifying touch and the absent touch'. 'Objectifying' touch, they argue, is the touch of discovery: the physician's hand becomes only a searching tool, probing and examining. There is no communication and no expectation of an answer other than to isolate the flaw. This leads seamlessly to the 'absent' touch of the machine that turns the patient into an inert lump to be viewed, entered and photographed. Thus touch in modern clinical practice implies no intimacy – no

need for a human response, and emphasises the alienation of the patient from his or her own diseased body. But this is to overstate the case and to ignore the possibility that clinicians can sustain more than one kind of relationship with the examined body in their minds, and can respond appropriately.

Touch is experienced differently by the toucher and the touched. The purpose for the clinician of placing an examining hand on the patient's abdomen is to take stock of the consistency, mobility and size of the underlying organs, and to determine their normality or otherwise. But, as human beings who themselves have experienced touch, clinicians are also aware of the two-way conversation involved in this intimate process. The attentive clinician knows that for the patient, the perceived intent and meanings can be many. As subject of the examination, the patient senses the gentleness of the hand, conveying care and concern; its responsiveness to a shiver of cold (if the hand is not warm), or to a flinch of pain when a tender spot is reached. Any pause as the clinician feels a mass or unusual shape is perceived by the touched body and snatched at by the mind of the patient. In these moments so much is conveyed about care and concern, but also about technical skill and professional decision-making. The skill displayed by the physician in the 'cool' intimacy of an expertly executed clinical examination is in fact care in action in that moment and in its intent. The 'brisk' doctor described by Kathleen Jamie in her essay 'Fever' demonstrates precisely this care:

> Leaning across the bed behind him, the doctor placed her stethoscope at precise points on Phil's back, and began to listen. As she listened she created around herself a screen of privacy. Her eyes disengaged. She folded herself into the stethoscope, in toward Phil's back, attending to the sound as a musician might. Then she began concentrating on an area midway down his right side. She was tracking something within his body, moving the stethoscope an inch to the left, and inch to the right, as if comparing two notes. Suddenly she was satisfied, and leaned back, tugging the stethoscope out of her ears. (p.103-4.)

The doctor whose sensibility has the capacity to oscillate between modes of being, at the same time sharing humanity and focussing on technical discovery, is aware of this: that the subject of coolly intimate clinical touch (the patient) perceives through the nature of this contact whether he or she is literally in good hands or not. Healing may well start here, with a sense of confidence (or otherwise) in the healer.

(Text: 1,760 words)

Further reading

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